

health clinic services and other ambulatory services on the basis of the cost reimbursement principles in part 413 of this chapter. For purposes of this section, a provider clinic is an integral part of a hospital, skilled nursing facility, or home health agency that is participating in Medicare and is licensed, governed, and supervised with other departments of the facility.

(b) For clinics other than provider clinics that do not offer any ambulatory services other than rural health clinic services, the agency must pay for rural health clinic services at the reasonable cost rate per visit determined by a Medicare carrier under §§ 405.2426 through 405.2429 of this chapter.

(c) For clinics other than provider clinics that do offer ambulatory services other than rural health clinic services, the agency must pay for the other ambulatory services by one of the following methods:

(1) The agency may pay for other ambulatory services and rural health clinic services at a single rate per visit that is based on the cost of all services furnished by the clinic. The rate must be determined by a Medicare carrier under §§ 405.2426 through 405.2429 of this chapter.

(2) The agency may pay for other ambulatory services at a rate set for each service by the agency. The rate must not exceed the upper limits in this subpart. The agency must pay for rural health clinic services at the Medicare reimbursement rate per visit, as specified in § 405.2426 of this chapter.

(3) The agency may pay for dental services at a rate per visit that is based on the cost of dental services furnished by the clinic. The rate must be determined by a Medicare carrier under §§ 405.2426 through 405.2429 of this chapter. The agency must pay for ambulatory services other than dental services under paragraph (c) (1) or (2) of this section.

(d) For purposes of paragraph (c) (1) and (3) of this section, "visit" means a face-to-face encounter between a clinic patient and any health professional whose services are reimbursed under the State plan. Encounters with more than one health professional, and multiple encounters with the same health professional, that take place on the

same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

[43 FR 45253, Sept. 29, 1978, as amended at 51 FR 34833, Sept. 30, 1986]

PART 455—PROGRAM INTEGRITY: MEDICAID

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AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

SOURCE: 43 FR 45262, Sept. 29, 1978, unless otherwise noted.

§ 455.1 Basis and scope.

This part sets forth requirements for a State fraud detection and investigation program, and for disclosure of information on ownership and control.

(a) Under the authority of sections 1902(a)(4), 1903(i)(2), and 1909 of the Social Security Act, Subpart A provides State plan requirements for the identification, investigation, and referral of suspected fraud and abuse cases. In addition, the subpart requires that the State—

(1) Report fraud and abuse information to the Department; and

(2) Have a method to verify whether services reimbursed by Medicaid were actually furnished to recipients.

(b) Subpart B implements sections 1124, 1126, 1902(a)(36), 1903(i)(2), and 1903(n) of the Act. It requires that providers and fiscal agents must agree to disclose ownership and control information to the Medicaid State agency.

[51 FR 34787, Sept. 30, 1986]

§ 455.2 Definitions.

As used in this part unless the context indicates otherwise—

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Conviction or *Convicted* means that a judgment of conviction has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

Exclusion means that items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Furnished refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a provider, or other supplier of

services. (For purposes of denial of reimbursement within this part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.)

Practitioner means a physician or other individual licensed under State law to practice his or her profession.

Suspension means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

[48 FR 3755, Jan. 27, 1983, as amended at 50 FR 37375, Sept. 13, 1985; 51 FR 34788, Sept. 30, 1986]

§ 455.3 Other applicable regulations.

Part 1002 of this title sets forth the following:

(a) State plan requirements for excluding providers for fraud and abuse, and suspending practitioners convicted of program-related crimes.

(b) The limitations on FFP for services furnished by excluded providers or suspended practitioners.

(c) The requirements and procedures for reinstatement after exclusion or suspension.

(d) Requirements for the establishment and operation of State Medicaid fraud control units and the rates of FFP for their fraud control activities.

[51 FR 34788, Sept. 30, 1986]

Subpart A—Medicaid Agency Fraud Detection and Investigation Program

§ 455.12 State plan requirement.

A State plan must meet the requirements of §§ 455.13 through 455.23.

[52 FR 48817, Dec. 28, 1987]

§ 455.13 Methods for identification, investigation, and referral.

The Medicaid agency must have—

(a) Methods and criteria for identifying suspected fraud cases;

(b) Methods for investigating these cases that—

(1) Do not infringe on the legal rights of persons involved; and

(2) Afford due process of law; and

(c) Procedures, developed in cooperation with State legal authorities, for